Providing CHIP and Medicaid services to Tarrant, Denton, Parker, Wise, Hood and Johnson counties.

Spring 2019

Cook Children's Health Plan

888-243-3312

CCHPProviderRelations@cookchildrens.org

What's inside

Provider Services Support

888-243-3312

Make sure to use the dedicated Provider Services Support telephone number 888-243-3312. Our dedicated staff is here to help you!

Provider Training Webinars

We'd love to have you or a member of your team attend one or more of our provider training webinars. The most up to date schedule can always be found under Education & Training on our website. Visit the link and register for a webinar at any time.

2019 Provider Training Webinar Schedule			
April 23, 2019	**April 25, 2019**	**May 22, 2019**	**May 23, 2019**
Provider Orientation * Call line: 1-844-740-1264 Event Number: 928 377 183	**SCP, Ancillary, Facility Provider Orientation *** Call line: 1-844-740-1264 Event Number: 925 762 593	**Provider Orientation *** Call line: 1-844-740-1264 Event Number: 929 560 968	**SCP, Ancillary, Facility Provider Orientation *** Call line: 1-844-740-1264 Event Number: 922 526 241
June 18, 2019	**June 19, 2019**	**July 30, 2019**	**July 31, 2019**
SCP, Ancillary, Facility Provider Orientation * Call line: 1-844-740-1264 Event Number: 922 526 241	**Provider Orientation *** Call line: 1-844-740-1264 Event Number: 920 373 651	**SCP, Ancillary, Facility Provider Orientation *** Call line: 1-844-740-1264 Event Number: 925 191 899	**Provider Orientation *** Call line: 1-844-740-1264 Event Number: 925 806 695

Provider Updates

Network Providers must inform both Cook Children's Health Plan and the Health and Human Services administrative services contractor of any changes to the provider's contact information including address, telephone and fax number, office contact name and email address, group affiliation, etc.

Providers must also ensure that the CCHP has current billing information on file to facilitate accurate payment delivery.

These changes may be reported on the Provider Demographic Information Change Request Form. The completed printed form can be faxed to Network Development 682-885-8403 or email cchpnetworkdev@cookchildrens.org.

Interpreter Services

CCHP will provide either face-to-face interpreter services or provide phone interpretation through CyraCom which offers translations of most of the commonly spoken languages around the world. Contact Provider Support Services at 888-243-3312 or CCHPInterpreterRequest@cookchildrens.org in order to request interpreter services. For interpreter services a 2 day advance notice is required. Please notify the Health Plan as soon as possible in the event of a cancellation.

Abuse, Neglect and Exploitation (ANE)

Cook Children's Health Plan and providers must report any allegation or suspicion of ANE to the appropriate entity. Additional state laws related to Cook Children's and provider requirements continue to apply.

Report by Phone:
Call CCHP 888-243-3312, press 5, then press the line of business (1 STAR, 2 CHIP, 3 STAR Kids), then press 3 for Care Management Department.

Report by Email:
STAR/CHIP - CCHPCaseManagers@cookchildrens.org.
STAR Kids - CCHPStarKidsServiceCoordination@cookchildrens.org

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Home and community support agencies (HCSSAs) – providers are required to report allegations of ANE to both DFPS and DADS
- Adult day care centers
- Licensed adult foster care providers

Contact:

- DADS at 800-647-7418.
- DFPS at 800-252-5400 or in non-emergency situations, online at txabusehotline.org

Report to Local Law Enforcement
If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109)
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107)
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS
    - This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center

Providers must provide Cook Children's Health Plan with a copy of the Abuse, Neglect and Exploitation report findings within one (1) business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Providers are required to train staff and inform Members on how to report Abuse, Neglect and Exploitation in accordance with Texas Human Resources Code, section 48 and Texas Family Code, section 261.

Long Term Services and Supports (LTSS)
Billing Tips

Diagnosis
Texas Medicaid requires providers to provide International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10 CM) diagnosis codes on their claims. The only coding structure accepted by Texas Medicaid is the ICD-10-CM.

- Diagnosis codes must be to the highest level of specificity available
    - Example: R69 – unspecified illness, would not be an appropriate primary diagnosis for Long Term Services and Supports
- All diagnosis codes submitted on a claim must be appropriate for the age of the client as identified in ICD-10-CM

Multiple Attendants
When billing for multiple attendants on the same day, you must submit separate claim lines.

Electronic Visit Verification Claims
It is recommended that you wait 48 hours after the visit before submitting your claim to CCHP. This allows CCHP time to get the EVV information to match to your claim.

Authorization
All LTSS services require prior authorization. Always indicate the authorization number on your claim form. The date of service, service codes and modifiers billed on your claim form must match the prior authorization form received from CCHP Care Management.

LTSS Billing Matrix
LTSS providers must utilize the Texas Health and Human Services (HHS) STAR Kids LTSS billing matrix when billing for STAR Kids.

You can locate the LTSS Billing Matrix on the Texas Health and Human Services (HHS) website, LTSS Billing Matrix and Crosswalk.

Manufacturer's Suggested Retail Price (MSRP)

When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement.

Durable Medical Equipment (DME) and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing. (TMPPM 2.2.6)

Authorization
When requesting a fee-for-service prior authorization for an unlisted procedure code, providers must submit the following information with the prior authorization request (TMPPM 5.2):

- Client's diagnosis
- Medical records to support medical necessity of the requested procedure
- Clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A procedure code that is comparable to the procedure being requested
- Documentation that the procedure is not investigational or experimental
- Place of service in which the procedure is to be performed
- The physician's intended fee for the procedure including the manufacturer's suggested retail price (MSRP) or other payment documentation

Manually Priced Claims
If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit the claim(s) with the MSRP that was submitted with the authorization request. The following information is also required:

- Authorization Number
- Provider Identifier
- Procedure Codes
- Dates of Service
- Types of Service
- Required Modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates on the claim must match the procedure codes in the authorization letter and the MSRP rates that were submitted with the authorization request.

*Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

(TMPPM 5.10.1)

Reimbursement
Providers may be reimbursed for DME either by the lesser of the provider's billed charges or the published fee determined by Texas Health and Human Services (HHS) or through manual pricing. If manual pricing is used, the provider must request prior authorization and submit documentation of either of the following:

- The MSRP or Average Wholesale Price (AWP), whichever is applicable
- The provider's documented invoice cost

Manually priced items are reimbursed as follows as is appropriate:

- MSRP less 18 percent or AWP less 10.5 percent, whichever is applicable
- The provider's documented invoice cost

(TMPPM 2.4.2)

Billing Tips

- Providers should submit a paper claim when billing for a service that includes an unlisted procedure
- Providers should submit a description of the service on the claim when billing an unlisted procedure
- Providers should submit a copy of the invoice or the MSRP for the service

Eligibility Verification

Providers MUST verify Member eligibility prior to rendering services. There are multiple ways to verify Member eligibility:

- Health Plan Identification Card
- CCHP Secure Provider Portal
  - www.cookchp.org
- TexMedConnect on the TMHP website
  - www.tmhp.com

Without eligibility, your services are not reimbursed.

Electronic Visit Verification Changes (EVV)

New Provider Data Validation Process – Improves Quality

The Texas Health and Human Services Commission (HHSC) is implementing an Electronic Visit Verification (EVV) provider data validation process for all contracted providers required to use EVV. This will improve data quality by standardizing EVV data within the Vesta EVV system, which will help reduce data element errors on visits. For more information on how this change affects you please visit HHSC's Electronic Visit Verification page.

Billing Policy Changes for Providers Required to use EVV

Effective September 1, 2019, all EVV relevant claims must be submitted to TMHP. Providers who submit their claims to their Managed Care Organization (MCO) on or after September 1, 2019 will have their claim(s) denied or rejected for resubmission to TMHP. Once the matching process has been performed by TMHP, all claims will be forwarded to the appropriate payer for final adjudication and processing.

Once a claim with EVV relevant services has been received at TMHP it will be matched against the EVV visits data sent to TMHP by Vesta. If the following data elements do not match, the claim will deny:

- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Date of Service
- Medicaid Identifier of the Individual
- Service Identifier as Healthcare Common Procedure Coding System and any associated Modifier(s)
- Units of Service delivered

For more information regarding this change please visit CCHP's Electronic Visit Verification page.

Sport/School Physicals

A Sport/School Physical is one of our Value Added Services. Services must be provided by an in-network Primary Care Provider (PCP). One physical will be reimbursed in addition to the Texas Health Steps (THSteps) medical checkup/well exam per calendar year for children ages 3 through 18. This would be a great opportunity to ensure Members are up to date on their medical checkups.

Billing Tips:

- Providers billing for STAR/STAR Kids should bill the Sport/School Physical and THSteps medical checkup on separate claims
- Providers billing for CHIP should bill both Sport/School Physical and Well exam on the same claim

- Providers should bill diagnosis code Z02.5 when billing for a Sports/School Physical
- Providers should billed an E/M code for the Sports/School Physical (CPT Codes 99201 - 99205, 99211 – 99215)

Texas Health Steps Quick Reference Guide

The Texas Health Steps (THSteps) Quick Reference Guide has been updated. The Condition Indicator Codes table now states that a condition indicator is required whether a referral is made or not. Vaccine procedure code 90649 has been removed from the human papillomavirus vaccine section and is no longer a benefit of Texas Medicaid.

Always verify you are using the most up to date THSteps Quick Reference Guide by visiting Texas Medicaid THSteps.

Texas Health Steps Medical Checkups Periodicity Schedule

Members are periodically eligible for medical checkups based on the THSteps Medical Checkups Periodicity Schedule. The age appropriate medical checkups listed on the periodicity schedule have been developed based on recommendations of the American Academy of Pediatrics (AAP) and recognized authorities in pediatric preventive health. For a copy of the THSteps Medical Checkup Periodicity Schedule visit the DSHS website.

Texas Health Steps Mandated Components

THSteps medical checkups must include regularly scheduled examinations and screenings of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth.

The following federal and state mandated components must be documented in the client's medical record for the checkup to be considered complete:

- Comprehensive health and developmental history, including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory test appropriate to age and risk, including lead toxicity at specific federally-mandated ages
- Health education including anticipatory guidance
- Dental referral

The Member's medical record must include documentation to support the rationale if a component was not completed, and a plan to complete the component(s) if not due to parent or caregiver concern or reasons of conscience, including religious beliefs. THSteps provides optional clinical records to assist the provider in the documentation of the required components. Locate the forms here.

Texas Health Steps Referral Status

Referral Indicators are no longer required but will be replaced with a Referral Status for checkups. A condition indicator must be submitted on the claim with the periodic medical checkup procedure code. Condition indicators are required whether a referral was made or not. The required condition indicators determine the results of the referral status during a THSteps medical checkup.

The following table includes the procedure codes, required condition indicators, and the resulting referral status for medical checkups.

Procedure Codes	Condition Indicator	Referral Status
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (Established client preventive visit)	NU (not used)	N (no referral given)
99381, 99382, 99383, 99384, and 99385 (new client preventive visit) -or- 99391, 99392, 99393, 99394, and 99395 (established client preventive visit)	S2 (under treatment) or ST* (new services requested)	Y (yes THSteps or EPSDT referral was given to the client)
* The ST condition indicator should only be used when a referral is made to another provider or the client must be rescheduled for another appointment with the same provider. It does not include treatment initiated at the time of the checkup.		

Vaccine Sequence

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence:

- The vaccine procedure code immediately followed by the applicable immunization administration procedure code
    - All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code

Each vaccine or toxoid procedure code must be submitted with the appropriate "administration with counseling" procedure code (90640 and 90461) or the most appropriate "administration without counseling" procedure code (90471, 90472, 90473 or 90474).

- If an administration with counseling procedure code is submitted with an administration without counseling procedure code for the **same** vaccine or toxoid, the administration of the vaccine or toxoid will be denied

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90471 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1

Billing Tips

- Providers are allowed to bill counseling and non-counseling administration fees on the same claim
- Providers are not allowed to use a combination of administration fees on one vaccine
    - Ex: You cannot bill a non-counseling code (90471) for component one and a counseling add on code (90461) for component two
- List of components can be found in the TMPPM Section 5.3.11.3
- Non-counseling codes
    - Providers can only bill one unit per non-counseling code (90471, 90472, 90473, and 90474)
    - Providers can only bill code 90471 once per day per claim
    - Providers may not bill code 90471 and 90473 on the same claim
- Vaccines given to Member 18 years or younger are only reimbursed the administration fee
    - The vaccine should be obtained from Texas Vaccine for Children (TVFC)
- Vaccines given to Adults or CHIP Perinate Members will be reimbursed for both the vaccine and the administration fee

For more information on vaccine administration visit the Texas Medicaid Provider Procedures Manual.

Non-Capitated Services

The following are programs (non-capitated services) available to Texas Medicaid and CHIP Members that are administered through HHSC on a fee for service basis.

STAR and STAR Kids non-capitated services are identified as:

- Nutritional products through Woman Infant and Children (WIC)
- Texas Health Steps dental (including orthodontia)
- Texas Health Steps Environmental Lead Investigation (ELI)
- Early Childhood Intervention (ECI) Targeted Case Management (TCM)
- Early Childhood Intervention Specialized Skills Training
- Case Management for Children and Pregnant Women
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation)
- Health and Human Services Commission's Medical Transportation Program
- DADS hospice serviced
- DADS or DSHS HCBS Waiver programs
    - Youth Empowerment Services (YES)
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities (DBMD)
    - Texas Home Living (TxHmL)
    - Home and Community-based Services (HCS)
- Nursing Facility services and Intermediate Care Facility (ICF) services
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members

CHIP non-capitated services are defined as:

- Texas Agency administered programs
- Case Management Services
- Essential Public Health Services

All network providers are encouraged to refer to and coordinate services for Members with the appropriate agencies.

Authorizations
Must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Payment
Must be submitted to TMHP according to the fee-for-service guidelines that are established for the same service.

Providers should refer to the appropriate TMPPM handbook for the applicable authorization request and claims filing guidelines.
Refer to the TMPPM: Section 1 General Information and Section 8 Carve-Out Services

Breast Pumps

Texas Medicaid and CHIP cover breast pumps and equipment when medically necessary after a baby is born and is a benefit when provided by Durable Medical Equipment (DME) suppliers and medical supply companies in the home. DME suppliers may deliver breast pump equipment to a client who is still in the hospital, but for claims purposes, the place of service should indicate the home setting.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for newborns when the mother does not have coverage under CHIP. The breast pump must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps when medically necessary for CHIP Perinatal newborns. Breast pump equipment must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, STAR Kids, and STAR+PLUS cover breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	STAR Health covers breast pumps when medically necessary for mothers or newborns. Breast pump equipment may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps when medically necessary for the newborn when the mother does not have coverage. The breast pump must be billed under the newborn's Medicaid ID.
* CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.			
** These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.			

The following breast pump procedure codes are a benefit of Texas Medicaid with the listed limitations:

Procedure Codes	Additional Information	Limitations
A4281, A4282, A4283, A4284, A4285, A4286	Breast pump parts for use with a pump that has been purchased. All parts must be submitted with modifier U8.	Each part - up to 2 times within 12 months from the breast pump date of purchase
E0602*	Purchase of a personal-use, manual breast pump	Once within 12 months from the date of birth
E0603*	Purchase of a personal-use, electric breast pump	
E0604*	Rental of a multiple-user, hospital-grade electric breast pump	Initial 60-day rental, followed by up to three 90-day rentals within 12 months from the date of birth
*Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider		
Modifier	**Description**	
U8	U8 denotes the replacement of a part for durable medical equipment and must be used when submitting claims for any breast pump parts	

Visit the Texas Medicaid Provider Procedures Manual (TMPPM) Breastfeeding Support Services for even more information.

CHIP Perinatal

CHIP Perinatal coverage provides care to unborn children of pregnant women who are not eligible for Medicaid and who have household income up to 202 percent of the Federal Poverty Income Level (FPIL). Once born, the child will receive Medicaid or CHIP benefits, depending on their income.

What are the CHIP Perinatal benefits for the unborn child?

- Up to 20 prenatal visits
  - During the first 28 weeks of pregnancy — 1 visit every 4 weeks
  - During weeks 28 to 36 — 1 visit every 2 to 3 weeks
  - 36 weeks to delivery — 1 visit per week
  - Additional prenatal visits are allowed if they are medically necessary
- Some laboratory testing, assessments, planning services, education and counseling
- Prescription drug coverage based on the current CHIP formulary, including prescription prenatal vitamins
- Diabetic supplies available through pharmacies with a physician prescription
- Hospital facility charges and professional services charges related to the delivery
  - For women with income from 199-202 percent of the FPL:
    - Both hospital and professional service charges paid through the CHIP perinatal health plan

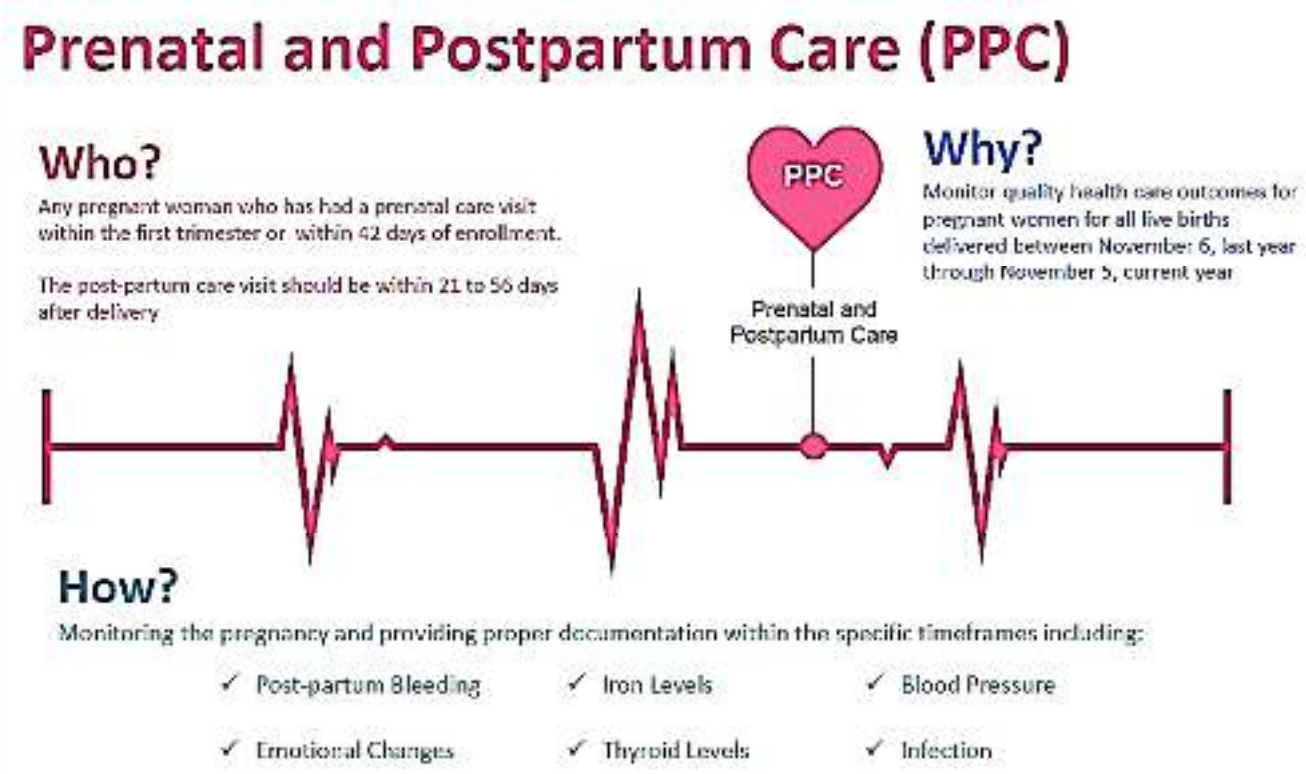
- For women with income at or below 198 percent of the FPL:
  - Professional service charges paid through CHIP
  - Hospital facility charges paid through Emergency Medicaid
    - Emergency Medicaid will need to be established before a claim can be paid to a Medicaid provider
    - HHSC mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date

More information about CHIP benefits for the unborn child is available in our Provider Manual.

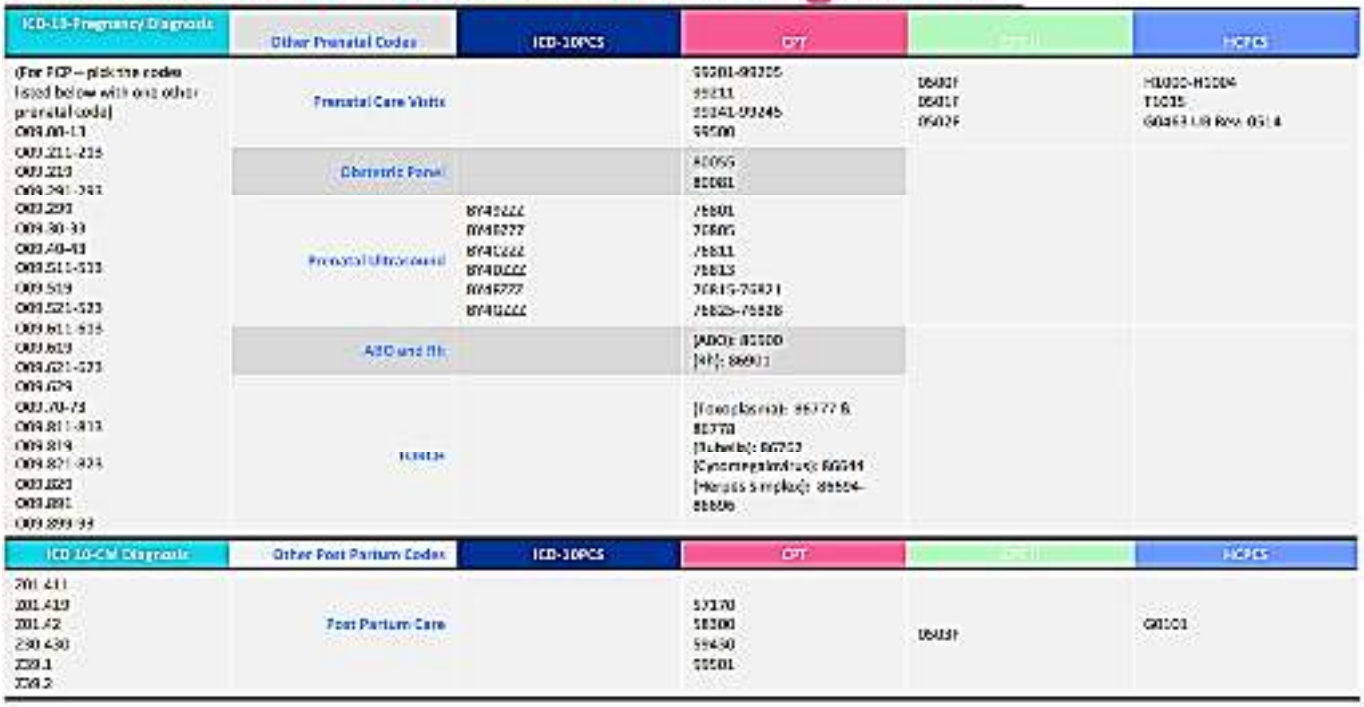
What about Postpartum visits?
Two postpartum care visits are covered under CHIP Perinatal. Although the eligibility terms at the end of the month of birth, the Mom is still entitled to two postpartum visits and these visits should be billed to CCHP. CCHP will reimburse the two postpartum visits even if eligibility shows termed.

For additional information please go to CHIP Perinatal FAQs

HEDIS Measures



Prenatal and Post Partum Billing Codes



ICD-10-Pregnancy Diagnosis	Other Prenatal Codes	ICD-10PCS	CPT	CPT II	HCPCS
(For POP – pick one code listed below with one other prenatal code)	Prenatal Care Visits		99201-99205 99211 99241-99245 99500	0500F 0501F 0502F	H1000-H1004 T1015 G0463 (8 Rev. 05) 4
	Obstetric Panel		80055 80081		
	Prenatal Ultrasound	0W4DXZZ 0W4D7ZZ 0W4DXZZ 0W4DXZZ 0W4F7ZZ 0W4DXZZ	76801 76805 76811 76813 76815-76817 76825-76828		
	ABO and Rh		[ABO]: 86900 [Rh]: 86901		
	[illegible]		[Toxoplasma]: 86777 & 86778 [Rubella]: 86762 [Cytomegalovirus]: 86644 [Herpes simplex]: 86694- 86696		
ICD-10-CM Diagnosis	**Other Post Partum Codes**	**ICD-10PCS**	**CPT**	**CPT II**	**HCPCS**
Z01.411 Z01.419 Z01.42 Z30.430 Z39.1 Z39.2	Post Partum Care		57170 58300 59430 S0601	0500F	G0101

Sterilization Consent Form

Effective April 26, 2019, changes will be made to the Sterilization Consent Form, instructions, and denial letter. These changes will impact all providers that use the Sterilization Consent Form.

The following changes will become effective April 26, 2019:

- The font size will increase, and the formatting will be updated
  - These changes will increase the number of pages in the consent form from one to three
- An italicized letter "X," will be added to indicate where a signature is required
- The Texas Provider Identifier (TPI) will no longer be required
- A free field box will be added to the top right of the Sterilization Consent Form with a note indicating that TMHP will not use it for any processing of the consent form
  - This field is for the provider's use only

Sterilization Consent Form Instructions

- The instructions will incorporate instructions for the free field text box for provider's use only
- A reminder has been added to the instructions of the Sterilization Consent Form to check for accuracy and to refer the provider to the instructions page on the TMHP website
- The asterisks for the TPI will be removed

Current Sterilization Consent Form Submission Deadline
CCHP will continue to accept the current version of the Sterilization Consent Form through October 23, 2019. ***Important:*** The new consent form is required on or after October 24, 2019. Any submissions of the previous version of the consent form will be denied.

Announcing the CCHP Therapy Services Handbook!

To ensure better outcomes for our Members, CCHP has created a comprehensive Therapy Services Handbook (Physical, Occupational, and Speech Therapy) for your reference. Our objective is to communicate our policies, protocols, and criteria to help ensure that ordering providers, therapists, and therapy agencies are able to maintain their focus on providing quality treatment services to our Members.

Visit our website to view the Therapy Services Handbook.

Therapy Services Monitoring

HHSC Quality and Improvement Services for STAR, STAR Kids and CHIP have required all Managed Care Organizations to obtain accurate and comprehensive information regarding therapy services provided to Members. Therapy Providers must report to Cook Children's Health Plan (CCHP) Network Development Department when a therapy provider is experiencing one or all of the following occurrences when treating a CCHP Member:

- Not accepting new patients
- Cannot treat the patient at the frequency assessed
- Cannot provide appropriate services for the patient needs
- Maintaining a "wait list" for evaluation of services

If any of these situations occur, Providers must submit notification to CCHP Network Development Department. If you are no longer accepting new patients, send written confirmation of the change by **e-mail**. If you cannot meet the service needs of the patient(s), send a list of the Members affected by attaching the **Therapy Notification to CCHP** document by **e-mail**.

Questions? Call Cook Children's Health Plan Provider Line at 888-243-3312 and ask to speak with a Network Development representative.

Therapy Services Retro-authorization

Effective 05/10/2019, CCHP will retro-authorize dates of service that are requested on the prior authorization form for therapy services within 30 days when medical necessity is present and does not overlap with previous authorization period.

Providers are encouraged to submit requests up to 30 days prior to expiration of the current authorization to minimize delay in services.

If you have any questions regarding this prior authorization update, please email CCHPPriorauthorizations@cookchildrens.org.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD stands for attention-deficit/hyperactivity disorder. It is one of the most common disorders among school-age kids. ADHD can also continue into adulthood. People with ADHD have trouble paying attention and staying focused. Many of them are also hyperactive and compulsive. Boys are three to four times more likely to have ADHD than girls.

A majority of our members are prescribed ADHD medications by their PCP. The key to effective long-term management of the child with ADHD is continuity of care with clinicians experienced in the treatment of ADHD.

CCHP has partnered with Beacon Health Options to develop an innovative strategy to positively impact members diagnosed with ADHD and lead to improved medication outcomes.

Beacon Health Options ADHD Outreach is designed to target members both in the initiation & maintenance phases. Here's how it works:

- Beacon receives weekly first-fill report and sends letters to members
- Letters are intended to provide basic information about ADHD diagnosis and to remind parents and caregivers of the importance of follow-up visits to prescribers

Beacon also provides additional ADHD resources to prescribers that can be found on the Beacon Health Options website such as:

- American Academy of Pediatrics ADHD Guideline
- ADHD Medication Treatment Algorithm
- Child ADHD Screening Tools

For more information you may contact Beacon:

- Phone: 855-481-7045
- Fax: 855-371-9227
- Provider Relations: 781-496-4769
- Provider Maintenance: 866-612-7795
- Credentialing Applications: 866-612-7790
- Recredentialing Applications: 866-612-7792
- Email: providerrelations@beaconhs.com
- Website: Beacon Health Options

Long-Acting Reversible Contraception Products (LARC)

Cook Children's Health Plan follows the Texas Medicaid Provider Procedure Manual (TMPPM) guidelines in order to reimburse providers, including hospitals and Federally Qualified Health Center's (FQHCs), appropriately for providing Medicaid covered LARC devices in the same amount, duration, and scope as the Medicaid benefit requires.

LARC products are available to Members through either Medicaid pharmacy or medical benefit.

Pharmacy Benefit
Providers can obtain LARC products with no upfront cost by submitting a completed and signed prescription request form to certain specialty pharmacies. The specialty pharmacy will ship the product directly to the practice address in care of the Member and bill Navitus for the product.

Providers can only bill for product administration at the time of service.

Medical Benefit
Providers may obtain LARC products through the existing buy and bill process, which requires providers to purchase LARCs from wholesalers or other sources before obtaining reimbursement upon insertion of the device, and opting to receive reimbursmenet for LARC products as a clinican-administered drug.

(TMPPM Section B.2.4)

Resource: ACOG - LARC Program

Billing Tips
- The insertion and/or removal of an intrauterine contraceptive device is reported using one of the following CPT codes:
  - 58300 Intrauterine contraceptive device insert
  - 58300 Intrauterine contraceptive device insert FAILED (append modifier 53)
  - 58301 Intrauterine contraceptive device removal
- Procedure code 58300 must be submitted on the same claim as procedure codes:
  - J7296, J7297, J7298, J7300, and J7301
- Procedure codes J7296, J7297, J7298, J7300 and J7301 may be reimbursed when they are billed with one of the following diagnosis codes:
  - Z30.011, Z30.013, Z30.014, Z30.018, Z30.02, Z30.09, Z30.2, Z30.40, Z30.41, Z30.42, Z30.430, Z30.431, Z30.42, Z30.430, Z30.431, Z30.432, Z30.433, Z30.49, Z30.8, Z30.9, Z98.51, Z98.52
- An office visit will not be reimbursed when billed on the same date of service as procedure code 58301
- The contraceptive capsule and the inplantation of the contraceptive capsule may be reimbursed using procedure code J7307
- Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Program
- Procedure code 11981 may be reimbursed for the insertion of a contraceptive capsul when it is billed with a family planning diagnosis code
- Procedure code 11983 may be reimburded for the removal with reinsertion of the contraceptive capsule when billed with a family planning diagnosis code

- Procedure codes for LARCs may be reimbursed in addition to the hospital Diagnosis Related Group (DRG) payment when insetion is performed immediately post partum

(TMPPM 2.2.5.2, 2.2.5.2.2, 2.2.5.3, and 2.2.5.4)

LARC Toolkit

The Texas Long-Acting Reversible Contraception Toolkit is a resource for Texas health care providers. The LARC Toolkit offers information and resources to help women's health care providers increase LARC availability to Texas women throughout their reproductive life cycle, including prior to the first pregnancy, during the postpartum period, and whenever family planning services are received. View the Texas LARC Toolkit

LARC Quick Course for Providers

Texas Health and Human Services (HHS) and Texas Health Steps offer a web-based "quick course" for providers about LARC. This course explains why and how to integrate LARC into routine clinical practice. View the LARC training: Texas Heath Steps Quick Course

Contact Us

Department	Type of Issue or Request	Email Address	Fax Number
Care Management	Prior Authorizations, Case Management, Referrals, Disease Management, Member Education	CCHPSTARKidsCCC@cookchildrens.org CCHPPriorauthorizations@cookchildrens.org CCHPCertsandAppeals@cookchildrens.org	682-885-8402 844-348-8402 682-303-0065 STAR Kids LTSS 844-843-0065
Claims Department	Claim Status, Payments, Appeals or Questions	CCHPClaims@cookchildrens.org CCHPClaimsAppeals@cookchildrens.org	682 885 2146 682-888-8404
Compliance Coordination of Benefits	Member and Provider Complaints, Fraud, Waste and Abuse Other Health Insurance, Third Party Resources, Cost Avoidance Verification Reports	CCHPCompliance@cookchildrens.org CCHPCOB@cookchildrens.org	682-303-0276 682-885-8401
Customer Service	Member Demographic Updates, PCP Changes, ID Card Requests, Value Added Services, Legal Documentation	CCHPCustomerSVC@cookchildrens.org	682-885-8401 STAR Kids 844-843-0001
Electronic Visit Verification Finance	Open Visit Maintenance Unlock Requests, EVV Questions Electronic Funds Transfer, Electronic Remittance Advice	CCHPEVV@cookchildrens.org CCHPFinance@cookchildrens.org	 682-885-8482
Interpreter Services	Interpreter Requests, Translation Requests, Interpreter Complaints	CCHPInterpreterRequests@cookchildrens.org	682 885 8401

Department	Type of Issue or Request	Email Address	Fax Number
Member Advocates	STAR Kids Member Assistance for Access to Care, Complaints and Appeals	CCHPMemberAdvocate@cookchildrens.org	682-885-8401
Network Development	Credentialing, Contracting, Demographic Changes (TPI, NPI, Billing Updates)	CCHPNetworkDev@cookchildrens.org	682 885 8403
Provider Relations	Provider Education and Training	CCHPProviderRelations@cookchildrens.org	682-885-8735
Quality	Quality of Care Concerns, HEDIS, Access and Availability	CCHPQualityImprovement@cookchildrens.org	682-885-8494

Vendor	Service	Email Address Website	Number
Availity	Claims Clearinghouse CHIP Payer ID: CCHP1 STAR/STAR Kids Payer ID: CCHP0	Website: www.availity.com	Ph.: 800-282-4548
Beacon Health Services	Mental Health Services	Email: TexasProviderRelations@beaconhealthoptions.com Website: www.beaconhealthoptions.com/providerlogin/	Ph.: 855 401 7045 Fax: 855 371 9227
National Vision Administrators	Vision Services	Email: Providers@e-nva.com	Ph.: 888-830-9690 Fax: 888-830-9580
Navitus Pharmacy	Prescription Services	Email: Providerinquiries@navitus.com Website: www.navitus.com	Ph.: 866 333 2757 Hotline: 877 905 6023 Fax: 866 505 4640

Paper Claims Mailing Address:
Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX. 76161-1295

Appeals, COB and General Mailing Address:
Cook Children's Health Plan
P.O. Box 2488
Fort Worth, TX. 76113-2488